**RESPONSE TO EMPLOYEE'S REQUEST**
**FOR FAMILY AND MEDICAL LEAVE**

***MEMORANDUM***

***Date:*** _____

***To:*** _____
*(Employee's name)*

***From:*** _____
*(Name of appropriate employer representative)*

***Subject:*** REQUEST FOR FAMILY/MEDICAL LEAVE

On _____, you notified us of your need to take family/medical
*(Date)*
leave due to:

- ☐ the birth of a child, or the placement of a child for adoption or foster care; or
- ☐ a serious health condition that makes you unable to perform the essential functions of your job; or
- ☐ a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care.

You notified us that you need this leave beginning on _____ and that you
*(Date)*
expect leave to continue until on or about _____.
*(Date)*

Except as explained below, you have a right under the FMLA for up to a total of 12 weeks of leave in a 12-month period for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent position with the same pay, benefits, and terms and conditions of employment on your return from leave. If you do not return to work following FMLA leave for a reason other than: *(1)* the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or *(2)* other circumstances beyond your control, you may be required to reimburse this agency for the employer's share of health insurance premiums paid on your behalf during your FMLA leave.

This is to inform you that: *(check appropriate boxes; explain where indicated)*

1. You are ☐ eligible ☐ not eligible for leave under the FMLA.

2. The requested leave ☐ will ☐ will not be counted against your annual FMLA leave entitlement.

3. You ☐ will ☐ will not be required to furnish medical certification of a serious health condition. If required, you must furnish certification by _____ *(insert date)* (must be at least 15 days after you are notified of this requirement) or we may delay the commencement of your leave until the certification is submitted.

4. We ☐ will ☐ will not require that you substitute accrued paid leave for unpaid FMLA leave. If paid leave will be used, the following conditions will apply: *(Explain)*

_____

_____

_____

5 (a) If you normally pay a portion of the premium for your health insurance, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows: *(Set forth dates, e.g., the 10th of each month, or pay period, etc. that specifically covers the agreement with the employee.)*

_____

_____

_____

(b) You have a minimum 30-day *(or, indicate if longer period, if applicable)* grace period in which to make premium payments. If payment is not made timely, your group health insurance may be canceled, *provided* we notify you in writing at least 15 days before the date your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work. We ☐ will ☐ will not pay your share of health insurance premiums while you are on leave.

(c) We ☐ will ☐ will not do the same with other benefits *(e.g., life insurance, disability insurance, etc.)* while you are on FMLA leave. If we do pay your premiums for other benefits, when you return from leave you ☐ will ☐ will not be expected to reimburse us for the payments made on your behalf.

6. You ☐ will ☐ will not be required to present a fitness-for-duty certificate prior to being restored to employment. If the certification is required but not received, your return to work

may be delayed until the certification is provided.

7. While on leave, you ☐ will ☐ will not be required to furnish us with periodic reports every 30 days on your status and intent to return to work *(see §825.309 of the FMLA regulations.)* If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the reverse side of this form, you ☐ will ☐ will not be required to notify your supervisor or a personnel officer at least two work days prior to the date you intend to report for work. You are required to contact the Personnel Office of this agency by or on _____ and every 30 days thereafter.
*Date*

8. You ☐ will ☐ will not be required to furnish recertification relating to a serious health condition. *(Explain below, if necessary, including the interval between certifications as prescribed in §825.308 of the FMLA regulations.)*

_____

_____

_____

_____

_____

_____

_____

9. ☐ You have requested that you be allowed to use the leave intermittently. A medical certification from your health care professional is required to justify the need for intermittent leave.

10. Your request to use intermittent leave for the birth or placement of a child for adoption or foster care ☐ is approved ☐ is not approved.